

GRANULOMA INGUINALE

DAVID FROST, M.D., M.P.H., and BERNARD F. RYAN, M.D., *Oakland*

THE increase in the negro population in California has been accompanied by a greater incidence of granuloma inguinale, a disease which heretofore had been considered a medical rarity in this area. Since most medical texts stress the inguinal manifestations of this disease rather than the earlier genital lesions, many cases have not been recognized promptly or have been confused with other venereal diseases.

Granuloma inguinale became a reportable disease in California in 1938. A review of Table 1 reveals that there has been a steady increase in the number of reported cases since that year. Eight cases, all negroes, were seen at the Oakland City Clinic in a period of six months. With the exception of one case, all of these patients presented lesions confined to the genitalia alone.

TABLE 1.—*Civilian and Military Cases of Granuloma Inguinale Reported in California for the Years 1938 Through 1945*

	California	
	Civilian	Military
1938.....	—	—
1939.....	3	—
1940.....	16	—
1941.....	29	1
1942.....	22	8
1943.....	22	12
1944.....	23	8
1945.....	43	17

NOTE: Granuloma inguinale was not reportable before 1938.
SOURCE: Morbidity Report Cards: January 1939 through 1945, California State Department of Public Health.

Although granuloma inguinale is a disease found primarily among negroes in the United States, about ten per cent of the cases reported in the past occurred among members of the white race. The accepted etiological agent is the Donovan body. This organism is now considered to be bacterial in nature rather than protozoan as had been believed heretofore.

The disease usually begins with a vesicle, papule, or nodule on the preputial orifice, the labia minora, or the vaginal wall. The surface of the original lesion becomes excoriated or eroded leaving an ulcer with a red beefy granular base. The margins are sharply defined, and in most instances, everted. The lesion bleeds easily upon trauma, such as would occur while obtaining a specimen for darkfield examination. The original lesion is usually followed by one or more "daughter lesions" which may coalesce to

From the Division of Preventable Diseases, Department of Public Health, Oakland, California.



Figure 1.—Donovan bodies within cytoplasm of monocyte X117.

form extensive ulcerative processes. There are usually no premonitory symptoms or constitutional upsets.

One of the important characteristics which is of great assistance in the differential diagnosis of lesions on the external genitalia, is that of the great chronicity of the lesions in granuloma inguinale. Many patients give a history of the spontaneous disappearance of the original lesions with a subsequent recurrence. It is not uncommon, however, to have a patient state that the granulating lesion or lesions have been present for many months, without progression or recession.

Most textbooks describe the inguinal lesions adequately but it must be stressed that these are relatively late manifestations of granuloma inguinale and not the early lesions. It has been our experience that although the disease is easily recognized by most physicians when it has extended to the inguinal region, many do not associate genital lesions with granuloma inguinale.

Unless syphilis complicates granuloma inguinale, the serological tests for syphilis are negative. The Ito and the Frei skin tests are also negative unless the patient has or has had chancroidal disease or lympho-granuloma venereum in the past.

The diagnosis depends on the demonstration of the pathognomonic Donovan bodies in spreads which are prepared by crushing curetted material from the lesions between glass slides. The Donovan body, which can be stained with Wright's or Giemsa stains, may be found extracellularly or within the cytoplasm of the large monocytes. These bodies look like a closed safety pin due to their elongated ovoid shape and intense bipolar staining reaction. (Figure 1.) Once seen they can hardly be mistaken in future examinations.

The disease usually responds favorably to antimony compounds. Fuadin is considered to be the

drug of choice.* Sulfonamides and penicillin do not affect the progression of the disease.

SUMMARY

The incidence of granuloma inguinale has been increasing in California in recent years. Textbooks fail to stress the initial genital lesions hence leading to a great delay in the diagnosis. The disease is exceedingly chronic and responds favorably to antimony compounds. Fuadin is considered to be the drug of choice in treating the disease.

* Since this article was submitted for publication, Greenblatt et al reported favorable results from the treatment of granuloma inguinale with streptomycin in *J. Ven. Dis. Inform.*, 28:183-189, Sept., 1947.



The Family Physician and Medical Education

H. E. THELANDER, M.D., *San Francisco*

A MEDICAL educator expressed a need by saying, "What we should have is a pediatrician for adults." The same thought was implied in a newspaper carrying a headline on "aged orphans." The present resurgence of interest in the general practice of medicine reflects the same thought. In other words, the disappearance of the old family physician is being felt.

Viewed not economically but basically, individuals and families need a health and welfare counselor. In the few areas where he is located and for the small per cent of families that he reaches, the pediatrician serves as such a counselor. He not only takes care of the sick, but he guides the health of the well, he does preventive work, he counsels on the mental and emotional development, and he advises the family on medical aid and consultants. But only the large centers have pediatricians and in these areas pediatricians serve only a part of even the childhood population—thus the comment on the need of a pediatrician for adults.

How this need is to be met is a question which concerns medical education, the health of the Nation, and the survival of the private practice of medicine. Medical education in this Nation has made extremely rapid strides, but as Allen has pointed out in "Medical Education and the Changing Order," time should be given now to evaluation of what has been learned and the practical application of this knowledge for the good of all. Medical education has developed along longitudinal lines in that it has been departmentalized into medicine, surgery, obstetrics, and pediatrics and these in turn into subdivisions. The trend has led to extreme specialization. Those students who have not wished to pursue a specialty have been given scant attention, which in itself casts

some aspersions on the group interested in general practice.

There is another way to look upon medical education, namely in cross-section. From this viewpoint medical schools should furnish the Nation with (1) medical teachers, to continue the educational process, (2) research workers, also an essential part of a progressive health program, (3) specialists as heretofore, (4) public health personnel, a field unique in itself, and (5) physicians trained in the science and art of practice. It should not be extremely difficult to determine approximately the number of physicians needed in each group and their percentage of the whole. This knowledge should be part of the information given students in order that both faculty and students, during the undergraduate training, could choose and select intelligently and according to fitness the best material for each field.

The training in the science and art of practice, at present a largely neglected part of medical education, should be developed along the lines of present pediatric training adapted to all age periods. The family physician should be well trained, but he should know his own limitations, and he should have access to continuation studies. The medical or technical part of his training should include internal medicine, pediatrics and obstetrics. Surgery at first should be limited to minor problems and extended in its practice only gradually, as is now done in pediatrics. Most pediatricians do little surgery, limiting themselves to repair of minor cuts and bruises, lesser degree burns, etc.; a few have taken surgical training and extended this to tonsillectomies, fractures and so on, depending on their qualifications by training. It certainly should be expected that many physicians in general practice would desire to extend their